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SCHEDULE OF MEETINGS

12 January-February	**Executive Board, eleventh session, Geneva** Included on the agenda of this session were regional matters; review of programme and budget estimates for 1954; expanded programme of technical assistance for economic development; organizational studies of (1) the education and training programme, including fellowships, and (2) regionalization; International Sanitary Regulations; medical supply services to Member States; review of reports of expert committees; and various other items relative to administrative matters and to the Sixth World Health Assembly.
16-21 February	**Joint UN/WHO/ILO/UNESCO Expert Committee on the Mentally Defective Child,** Geneva

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MENTAL HEALTH AND CHILD DEVELOPMENT

Much of the work of WHO in Europe takes the form of affording opportunities for specialists in particular medical sciences to enlarge and share their experience with colleagues from other countries. This is achieved not only through the granting of fellowships but also through sponsorship of, or participation in, seminars and symposia on various subjects.

A great deal of attention has been focused on mental health, and advisory services to individual governments have been followed by co-operative programmes comprising training courses, symposia, and/or seminars on questions such as industrial psychiatry, alcoholism, general psychiatry, and the mental health aspects of public-health nursing. In 1952, special consideration was given to the mental health of children and its relation to physical development and health.

CHILD PSYCHIATRY AND CHILD GUIDANCE WORK

In the spring (21 April to 3 May 1952), the Norwegian Government, the United Nations (Division of Social Affairs), and WHO joined in sponsoring a Scandinavian Seminar on Child Psychiatry and Child Guidance Work. This seminar, held near Lillehammer, Norway, brought together for lectures and discussions 44 physicians, psychiatrists, psychologists, and social workers engaged in child guidance activities in Denmark, Finland, Iceland, Norway, and Sweden. The lecturers were Dr. J. Bowlby (Tavistock Clinic, London), Dr. S. Escalona (Child Study Center, Yale University, USA), Professor E. Erikson (Austen Riggs Foundation, Stockbridge, Mass., USA), Dr. E. Miller (St. George's Hospital, London), Professor F. Redl (Wayne University, Detroit, Mich., USA), and Dr. A. Répond (Maison de Santé de Malévoz, Monthey, Switzerland). A summary of the lectures and of some of the discussions follows.[1]

Normal and Deviant Social Development of the Child

Normal development

Social development of the child is manifested primarily through physical functions. It is not definable in purely social terms but involves a social interpretation of physiological functioning, sensory perception, and other related mechanisms.

[1] This summary is drawn from a report on the seminar which has been issued by the WHO Regional Office for Europe, Geneva.

The infancy period is of the greatest importance to the child and, ultimately, to the emotional and social adaptation of the adult. During his first year of life, the baby changes from a purely reactive creature into a person aware of himself and others, capable of expecting certain things, of remembering and being aware of his identity as a family member. It is a time of great complexity of experiences and of constant change. From his first day onwards there is an interchange of responses between a baby and the people in his environment, and anything that goes on within him expresses itself in his relationship to other people.

What an infant needs from his social environment is satisfaction of his needs as they arise. These needs appear to be largely physical, and pleasure and gratification to be experienced mainly in the form of bodily well-being. Small details in the care of a baby may contribute to his conception of the kind of place the world is and may affect his later orientation to other human beings and to his environment. Wholesome development depends upon his being loved by those who take care of him. In this connexion, his relationship with his mother is particularly significant. In the care of the baby there is a system of reciprocity in which two sets of stimuli reinforce each other : as the mother performs certain tasks for the baby, they elicit responses in him which in turn elicit in her a desire to give him more of what she thinks he needs.

The requirements and development of the child after the first year of life are more difficult to discuss in general terms because much depends upon the specific circumstances of each particular child's existence. However, there are certain developmental changes, with corresponding changes in the expressions of the child's interest, which appear with great regularity, although they may assume different forms. During the second year and the first part of the third year, a child's social development seems to be characterized by intensity of emotion and a paradoxical type of behaviour in which his own responses to the outside world are exploratory, experimental, and manipulative, but in which he demands extreme conservatism on the part of others, insisting that everything be done in the same way, that the same games be repeated, etc. Since he is still not equipped to predict the behaviour of others, nor to know the limits to which he can use his own powers, he requires a certain sameness to help him understand the world. At this stage it is important for other people to aid the child in exploring his power to make the world as predictable and comprehensible as possible.

Deviations from normal development and causes of maladjustment

Discussion of deviations from normal development is complicated by the fact that a norm has never been established, since the norm varies with the particular culture in which the child develops. It should start,

however, with consideration of the possible roles which body-growth and instinctual drives may play in the creation of social crises for the child during his early years, and with the questions of how the environment reacts on these crises and what will be the general outcome for the child in his development into a " healthy person "—defined by Freud as one who " can work and love ".

The development of the child up to puberty may be described in terms of psychosexual stages and concomitant basic attitudes :

1. *Infancy.* This is the incorporative stage, in which the taking-in by the child of food and drink implies not only acceptance of what is given but also identification with the giver, which, in turn, calls forth the ability to give. During this stage there should be established a basic trust—a feeling that, although life is hard and there are always problems, pain, anger, and disruption, there are also, ultimately, ways and means of trusting certain people, of trusting oneself, one's own body and one's ability to control oneself, and of trusting the world in general. The antithesis is basic mistrust. A child may learn to mistrust what he receives, for various reasons, one of them being the disturbing element constituted by a person who alternatively gives too much or too little.

There is a crisis in this first stage when an infant begins to bite. He then becomes more aware of things and more aggressive about what he wants to incorporate.

2. *Early childhood.* At this stage the conflict becomes one between autonomous will and shame and doubt. The problem is to learn to trust one's own decisions as to what one wants or doesn't want, to learn that one has a choice and an autonomous will and, at the same time, that this will must be adjusted to the demands of the environment. Failure to develop this autonomy leads to feelings of shame and doubt.

It is here that the question of control arises. The child can now control certain muscular expression. The ability to retain or to eliminate faeces and urine through sphincter control gives the child his first sense of autonomy; emotionally it means that he can decide what he keeps or gives, what he takes or throws away, whom he accepts and whom he rejects. On the other hand, he begins to accept control imposed by the environment (e.g., toilet training). It is at this stage that every culture begins to approach the child with demands and with measures which will test his ability to accept control. The issue becomes how to learn to control himself without feeling over-controlled by the environment. The mother can impart the demands of the environment to the child in such a way that he can incorporate them and accept the relevant action as if he desired it himself.

3. *Play age.* This stage manifests itself differently according to the sex of the child : for boys, it is a period of intrusiveness; for girls, of inclusiveness. Boys' play becomes more aggressive, while the activities

of girls develop towards a configuration of feminity. This is the stage during which male initiative and female initiative are learned. Inhibition of the development of initiative may result in feelings of guilt in relation to suppressed goals, excessive will to succeed, general submissiveness, or actual pathological conditions. The amount of activity-passivity, intrusiveness-inclusiveness, which the child develops is determined by education, which is rooted in the values of each cultural group.

4. *School age, or latency period.* During this stage there is a tendency towards sublimation, towards work. The child is now ready to go to school, where he learns to enjoy the pleasure of completing a task and of working with others. He needs to feel some coherence of his school experience with the work of adults, an integration of his work with that of his parents.

Etiological factors of maladjustment within the child

Ideas about the heredity of mental disorders have occurred sporadically in the past 150 years, going from an exaggerated belief that all problems could be solved through knowledge of hereditary mechanisms to reaction against this exaggeration in the form of complete negation, even with regard to such conditions as hereditary feeblemindedness. Generally there is much confusion of ideas concerning heredity, which is transmitted through the generative cell, and congenital elements of the constitution, which may be produced in the intra-uterine stage. In any case, the theory of heredity is insufficient for an understanding of developmental processes. The most satisfactory explanation of normal and abnormal development is a psycho-biological view built upon the epigenetic theory of the development of the ovum.

According to the epigenetic theory, the foetus develops from some earlier nucleus, each part of which has its own time of development. When the sperm penetrates the ovum, a so-called organizor arises, and cell division proceeds. There follow organizors of the second, third, and higher orders. Each of these organizors plays a role in the stages of the egg development, in the epigenetic cycles, until the child is born. An interruption in the early development of any part causes faults of growth and development, and damage to one part affects the hierarchy of the whole. On the other hand, if interruption occurs at the end of a developmental stage, the damage may not be final.

The psycho-biologist and the psychoanalyst take over where the biologist stops. They regard such phenomena as puberty and the cessation of menstruation, which take place at certain ages, as evidence of the continuation of epigenetic development. They believe that there must be organizors latent in the constitution which become active at certain stages and inactive again when their roles in the " organization " of the respective stages have been fulfilled.

It seems that at different stages there are certain automatic mechanisms which must run their whole course (e.g., sucking) and which cease when they have played their part. However, if such a mechanism is interrupted before it has spent its energy and fulfilled its role in development, then problems arise and the entire organism is disturbed. Disturbances of the cycles may manifest themselves in the form of " bad habits " which may have to be corrected through education or other means. Following the epigenetic principle, it may be said that the optimum time for physiological restrictions is at the end of each developmental stage.

Application of the theory of epigenesis can help to eliminate the dangerous concept that some individuals are born with an unalterable psychopathic constitution, which amounts to an idea of relentless predestination. It can be shown that there is no such thing as constitutional psychopathy, though there may be a constitutional predisposition, a " psycho-allergy ", which is not specific. Psychoanalysis commonly reveals disturbances in epigenetic development which account sufficiently for abnormal behaviour without having recourse to the theory of constitutional psychopathy.

Diagnostic Methods in Child Psychiatry

There is no psychological test which in itself can establish a diagnosis, but many of the tests can be used to determine a developmental level, personality structure, and specific psychopathology. The most important instrument in evaluating the results of such tests is the objective human observer, and psychologists must develop within themselves a capacity for detailed, accurate, intuitive observation.

A variety of tests must be performed on the same child in order to arrive at a diagnosis. What is desired is a picture of the whole personality at a certain level of development, working as a unit and not characterized only by certain traits, since there is a dynamic relationship among all parts of the whole organism. Testing must be combined with observation, and the results of both must be related to what has been learned about the child's social history.

In giving any kind of test, three types of analysis should be carried out : an item analysis, in which one tries to understand what kind of function is elicited by each item; a scatter analysis, in which one thinks about the dispersion of successes and failures as a pattern; and an analysis of the relationship of the tester to the child.

Preventive Measures

Practical measures for prevention of psychic disturbances must be based on knowledge of the etiology of such disturbances. Although there is considerable disagreement among psychiatric and allied workers about

the origins of maladjustment, one etiological factor which has gained recognition during recent years is the separation of the child from his mother. Deprivation of the mother during the early, formative years is a common cause of emotional trouble, often manifesting itself in inability to establish satisfactory relationships with other human beings in later life.

Zoological studies of the relationships which birds, cats, dogs, and horses make in their early years have shown that these relationships are not very different from those which human beings make. The young organism exhibits a tremendous drive towards the formation of a dependent relationship with an adult, and the way in which this develops has a considerable effect on its character and social life in later years. Deprived of satisfactory love relations in early life, all kinds of animals suffer the effects throughout their subsequent development.

The ability to co-operate with other human beings is one of the natural social functions which must be developed in early childhood. A certain degree of co-operation may be taken as a norm which everyone, regardless of the culture in which he lives, must attain if he is to be considered normal. Mental illnesses may be looked upon as breakdowns in the capacity to make continuous co-operative relationships with other people. Since the first continuous co-operative relationship any individual makes is with his parents, particularly with his mother, interruption or deprivation of the development of this relationship is a fundamental source of psychological maladjustment.

The first step in instituting preventive measures is to make members of the professions concerned—doctors, social workers, administrators, hospital personnel, etc.—realize the significance of parent-child relationships in the development of mental health, so that separation of the child from his parents, particularly from his mother, may be avoided if at all possible. This has implications especially with regard to hospitalization and institutionalization of children, both of which are dubious solutions to particular problems from an economic as well as from a mental health standpoint.

Treatment

Group therapy

Group therapy, a comparatively new form of treatment, is " an attempt to manipulate a segment of the environment, particularly that segment which has inherent therapeutic values ". It offers many new possibilities, but it is neither shorter nor cheaper than other forms of therapy.

There are six types of activity which might be termed group therapy :

1. Mental hygiene group-work. Example—a club for adolescent girls which may provide a needed social stimulus at the right moment.

2. Group therapy for special case-work referrals. Example—a church-sponsored project in which a case-worker helps delinquent girls to join a club which may foster valuable group relationships.

3. Creation of group experience. Example—camps for special groups, such as delinquents or youngsters of somewhat low I.Q. (Intelligence Quotient).

4. Decontamination from artificial situations. Example—group activities in a detention home, hospital, etc.

5. Group therapy with a view to diagnosis. Example—group activities in observation centres which may aid in making a diagnosis.

6. Group therapy proper. The group medium itself may be used for treatment purposes. There are various " levels " of meaning for even this use of the term " group therapy " :

(*a*) A partial area of a child's problem may be treated through group therapy while the major part of his pathology is approached through case-work or individual treatment.

(*b*) Following individual therapy, the group therapist may try to help a child translate the potentialities " liberated " through this therapy into the " actualities of living ".

(*c*) Group therapy may be used for treating the whole disturbance.

The effect of group psychology and the influence of " group climate " on individual behaviour must be taken into account in applying group therapy. There is need for further study of these factors so that full use may be made of the therapeutic possibilities of group relationships and activities.

Individual therapy

Analytical therapy of children takes the form of fantasy activity, promoted by play. In a play situation a child may work out symbolically his hidden conflicts. The therapist must provide an " atmosphere for expression " as well as the essential play material, of which he himself becomes a part. He is a " source for projection of fantasy figures and a lightning conductor for the passage of emotional potentials " from the child to himself.

Interpretation of the child's private language calls for analytic insight on the part of the doctor. Delay in interpretation is desirable in order to learn the individual expression of the cultural experiences of the child, which determine the form of the idiom and specific culture contacts. The younger the child, the less is the need for interpretation, since very young children form a rapport with adults on a quasi-reality basis.

In the latency stage (school age), drawing and conversation take the place of play as an analytical tool. Dream analysis may be of value in children from the age of eight up to adolescence.

Treatment of the parents must be undertaken along with that of the child. While the child is being handled by the therapist, the mother should receive social psychiatric help. In some instances, the child-parent relationship may be used in a quasi-analytical way.

Residential and institutional care

On the basis of analysis of reasons for referrals to institutions for children, it may be said that the following are the functions of such institutions : (1) to foster an ego development in the maladjusted child, (2) to encourage social awareness, (3) to restore trust, (4) to aid the establishment of new relationships to substitute for previous unsatisfactory ones, and (5) to make use of all the abilities that the child possesses. The decision to send a child to an institution for treatment of behaviour disorders involves insight into both individual and social factors : the positive and negative attitudes towards a given society which the child has acquired and the social influences which have given the institution its character must both be taken into account. Referral to an institution is never an easy decision to make, and there is an urgent need for determining the criteria of selection for such referrals.

Generally, institutions of the camp-life or cottage-type structure are favoured. It is advisable that there be not more than thirty children in any institutional unit, and this group should be subdivided, if possible, into groups of not more than five or six children.

One of the most important problems in institutional care of children is the selection of suitable personnel for the institution. All who have personal contact with the child—domestic help, office personnel, and others, as well as the professional staff—should be carefully chosen. Psychological maturity and warmth of nature combined with sympathy for, and love of, children are among the desirable qualifications. Selection of personnel should be made by a combination of individual interview plus a group interview, other members of the staff participating in the latter.

In-service training of new personnel, conducted by someone familiar with the institution, is preferable to the giving of lectures by experts from " outside ". To interest really good personnel, an institution should try to offer challenging work experiences with the children, good supervision and in-service training, and well-balanced group-life for staff members.

Another point for consideration in an institution is its routine. Custom relieves the child of constantly making his own decisions, which has a calming effect; but it also means that the routine must be wisely defined in terms of the clinical needs of the disturbed children.

A fundamental concern in institutions for children is the degree of permissiveness which may be allowed. The scale of levels of permissiveness includes (1) frank permissiveness, (2) acceptance of certain behaviour patterns although not approving of them, (3) allowing scope for learning,

(4) emphasis on the limits in order to increase conscious awareness of what is acceptable behaviour, and (5) actual forcible interference. Those working with the child must know the minimum demands which should be made in order to allow guilt-free expression of his impulses. In addition, behaviour which is harmless must be differentiated from that which is dangerous to the group situation and an attempt made to forestall the latter. Children can " inebriate " each other, i.e., loss of control on the part of one child can have such a contagious effect that the whole group may become unmanageable. An increasing understanding of the " laws of contagion and of the danger moments of behaviour " will enable the institution staff to relax much more and to know when and how to interfere.

Those who work with maladjusted children must be able to take many set-backs. Lack of evidence of improvement in behaviour should not be considered a sign of failure. Behaviour may become temporarily disorganized while mental growth is taking place in one particular area, and in actual clinical progress there is temporary confusion of behaviour. It is important to understand the various stages through which the delinquent child passes in order to accept certain types of behaviour at certain times, realizing that ground is being gained even though the contrary seems to be true.

MENTAL HEALTH AND INFANT DEVELOPMENT

In August 1952, WHO participated in another international seminar on the mental health of infants in relation to their emotional environment. This seminar, conducted by the World Federation for Mental Health, took place in Chichester, Great Britain. WHO provided fellowships for more than 50 persons to attend this three-week course—psychiatrists, psychologists, anthropologists, public-health doctors, public-health nurses, psychiatric social workers, and others from 30 different countries. The members of the teaching staff, in which all of the above-mentioned professional disciplines were represented, came from France, the United Kingdom, and the USA.

This seminar was based on a series of clinical studies of children, the case material being gathered from three countries—France, the United Kingdom, and the USA—in which there was already a considerable volume of work in this field. Six completely documented studies were made available from USA research projects, one of which had been in operation for more than twenty years. In France, nine children from three different social milieux were studied for the seminar. Case studies of four children, and information concerning a psycho-social investigation, were presented by British contributors. In addition, special topics were treated by faculty members who came for short periods.

Some of the points singled out by Dr. K. Soddy, director of the seminar, for presentation in a report to the World Federation for Mental Health, are summarized hereafter.

In a lecture on child development patterns in the USA, Professor E. Jackson, of Yale University, compared the advice given in the two best-known manuals on infant care in the USA. The general trend appears to be one of " enjoy your baby as he is ", but this enjoyment seems to be somewhat self-conscious, less spontaneous than in certain other countries. In one of the discussions, the reluctance of many American parents to be authoritative was described. Dr. M. Mead, anthropologist, pointed out that some middle-class parents are bringing up their children at a higher social level than themselves, which makes it impossible for them to serve as models for their children.

The French surveys of different social groups revealed that social practices are similar but environments very different, with results that are likewise different. There were many examples to show that, provided they are not subminimal, socio-economic conditions are less important influences than general atmosphere and the manner of living within the home. Dr. Jenny Roudinesco, of Paris, traced the French family down a patriarchal line, but with the mother, like the Roman matron, supreme in the home. The stability which the French family owed to its rooting in the soil is, perhaps, being shaken, and there is a consequent danger of an increase of anxiety in mothers.

Professor D. R. MacCalman, of Leeds, Great Britain, presented information concerning a study in an industrial area where the notion prevails that life is hard and that a child should be reared to fit him for such a life. It seems that British families are more concerned with discipline than those in France or the USA and that it is not always easy for mothers to enjoy their children.

Considerable attention was given to the effects of broken homes upon the mental health of infants, particularly of the separation of the child from his mother. The arrested emotional and social development of infants entrusted to institutions was emphasized in lectures and in films. Miss Anna Freud, of the Child Study Centre, London, described her experiences with children separated from their parents during the war. She found that the direct effect of this separation on babies under one year of age was a great increase in somatic illness; older children showed disturbances of emotional development and regressive phenomena. She concluded from her observations that sibling jealousy occurs via the parents, and that without parents there is more group identification. Miss Freud urged the adoption of a principle of no separation of brothers and sisters.

Dr. Mead, in giving an anthropological orientation to the seminar, stressed the need for adaptation to a changing environment. Her film " Dance and Trance in Bali " provided an illustration of a cultural pattern

in which a child is born into a known world and in which society has elaborate, fixed devices to exteriorize internal anxieties in the form of stage plays. This was contrasted with Western cultures, in which an attempt is made to prepare children for meeting the unknown future by making their primary relationships secure.

International Non-Proprietary Names

To avoid the inconveniences which result from the fact that the same drug is often known by different names in different countries, WHO proposes to governments international non-proprietary names, recommending that these be adopted, in so far as possible, and protected accordingly.

Several lists of non-proprietary names have already been published—in Volume I of the International Pharmacopoeia, as titles of monographs, and in the *Technical Report Series*.[1] Other lists, such as that which follows,[2] will be published in the *Chronicle* from time to time as new international common names are proposed.

The various steps in the selection of international non-proprietary names and the principles which govern this selection were recently explained in a *Chronicle* article.[3]

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
acebrocholum acebrochol acébrochol	acetodibromodihydrocholesterol acéto dibromo dihydro cholestérol
acidum iopanoicum iopanoic acid acide iopanoïque	3-(3-amino-2,4,6-triiodophenyl)-2-ethylpropanoic acid acide (amino-3 triiodo-2,4,6 phényl) éthyl-2 propanoïque
amoxecainum amoxecaine amoxecaïne	*N,N'*-triethylethylenediamine-*N*-β-ethyl *p*-aminobenzoate *p*-aminobenzoate de *N,N'*-triéthyléthylènediamine *N*-β-éthyle
aurothioglycanidum aurothioglycanide aurothioglycanide	auromercaptoacetanilide auromercaptoacétanilide

[1] *World Hlth Org. techn. Rep. Ser.* 1951, **35**, 28; **43**, 30; 1952, **50**, 31

[2] This supersedes unpublished document WHO/Pharm/253

[3] *Chron. World Hlth Org.* 1952, **6**, 322

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
benzoestrolum benzoestrol benzoestrol	3-ethyl-2,4-bis(*p*-hydroxyphenyl)hexane éthyl-3 bis(*p*-hydroxyphényl)-2,4 hexane
benzpyrinii bromidum benzpyrinium bromide bromure de benzpyrinium	1-benzyl-3-(dimethylcarbamyloxy)pyridinium bromide bromure de benzyl-1(diméthyl carbamyl oxy)-3 pyridinium
bibrocatholum bibrocathol bibrocathol	bismuth derivative of tetrabromopyrocatechol dérivé bismuthique de tétrabromo pyrocatéchol
camphotamidum camphotamide camphotamide	camphosulfonyl-*N*-methylpyridine-β-diethyl-carbonamide β-diéthyl carbonamide de la campho sulfonyl-*N*-méthyl pyridine
carbromalum carbromal carbromal	α-bromo-α-ethylbutyrylurea α-bromo-α-éthyl butyryl urée
chlorazodinum chlorazodin chlorazodine	α,α′-azo-bis(chloroformamidine) α,α′-azo bis(chloroformamidine)
chlornaphazinum chlornaphazine chlornaphazine	2,2′-dichlorodiethyl-β-naphthylamine dichloro-2,2′ diéthyl β-naphtylamine
chlorpromazinii chloridum chlorpromazinium chloride chlorure de chlorpromazinium	2-chloro-10-(3′-dimethylaminopropyl) phenothiazinium chloride chlorure de chloro-2 (diméthylamino-3′ propyl)-10 phénothiazinium
chloropyraminum chloropyramine chloropyramine	*N*-β-dimethylaminoethyl-*N*-*p*-chlorobenzyl-2-aminopyridine *N*-β-diméthylamino éthyl-*N*-*p*-chlorobenzyl amino-2 pyridine
corbadrinum corbadrine corbadrine	1-(3,4-dihydroxyphenyl)2-aminopropanol hydrochloride chlorhydrate de (dihydroxy-3,4 phényl)-1 amino-2 propanol
cyclizinii chloridum cyclizinium chloride chlorure de cyclizinium	*N*-diphenylmethyl-*N′*-methylpiperazinium dichloride dichlorure de *N*-diphénylméthyl-*N′*-méthylpipérazinium
cyclopentaminum cyclopentamine cyclopentamine	*N*,α-dimethylcyclopentylethylamine *N*,α-diméthylcyclopentyl éthylamine

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
dextromethorphanum dextromethorphan dextrométhorphane	(+) 3-methoxy-*N*-methylmorphinan (+) méthoxy-3 *N*-méthylmorphinane
dextrorphanum dextrorphan dextrorphane	(+) 3-hydroxy-*N*-methylmorphinan (+) hydroxy-3 *N*-méthylmorphinane
dibemethinum dibemethine dibéméthine	dibenzylmethylamine dibenzyl méthylamine
dimenhydrinatum dimenhydrinate dimenhydrinate	2-(diphenylmethoxy)*N*,*N*-dimethylethylammonium 8-chlorotheophyllinate chloro-8 théophyllinate de (diphénylméthoxy)-2 *N*,*N*-diméthyl éthylammonium
dimoxylinii phosphas dimoxylinium phosphate phosphate de dimoxylinium	6,7-dimethoxy-1-(4′ethoxy-3′-methoxybenzyl) 3-methylisoquinolinium phosphate phosphate de diméthoxy-6,7 (éthoxy-4′ méthoxy-3′ benzyl)-1 méthyl-3 isoquinoléinium
diphenanum diphenan diphénane	4-benzylphenyl carbamate carbamate de benzyl-4 phényle
diperodoni hydrochloridum diperodon hydrochloride chlorhydrate de dipérodon	3-(1-piperidyl)1,2-propanediol dicarbanilate hydrochloride chlorhydrate du dicarbanilate de (pipéridyl-1)-3 propanediol-1,2
dixanthogenum dixanthogen dixanthogène	diethyldixanthogen diéthyldixanthogène
furostilboestrolum furostilboestrol furostilboestrol	diethylstilboestrol furoate furoate de diéthylstilboestrol
furtrethonii iodidum furtrethonium iodide iodure de furtréthonium	furfuryltrimethylammonium iodide iodure de furfuryltriméthylammonium
glucosulfamidum glucosulfamide glucosulfamide	glucose sodium bisulfite compound of sulfanilamidomethanol dérivé glucosé bisulfité sodique de sulfanilamido méthanol
glycobiarsolum glycobiarsol glycobiarsol	bismuthyl 4-*N*-glycoloylaminophenyl arsinate *N*-glycoloylamino-4 phényl arsinate de bismuthyle

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
homatropini methylbromidum homatropine methylbromide méthylbromure d'homatropine	
hydralazinum hydralazine hydralazine	1-hydrazinophthalazine hydrazino-1 phtalazine
hydrocortisonum hydrocortisone hydrocortisone	17-hydroxycorticosterone hydroxy-17 corticostérone
hydroxyprocainum hydroxyprocaine hydroxyprocaïne	diethylaminoethanol 4-aminosalicylate amino-4 salicylate de diéthylamino éthanol
hydroxytetracainum hydroxytetracaine hydroxytétracaïne	2-dimethylaminoethanol 4-*n*-butylamino-salicylate *n*-butylamino-4 salicylate de diméthylamino-2 éthanol
ibrotamidum ibrotamide ibrotamide	ethyl*iso*propyl-α-bromacetamide éthyl *iso*propyl α-bromacétamide
intermedinum intermedine intermédine	active principle of the *pars intermedia* of the pituitary principe actif du lobe intermédiaire d'hypophyse
iproniazidum iproniazid iproniazide	1-*iso*nicotinyl-2-*iso*propylhydrazide *iso*nicotinyl-1 *iso*propyl-2 hydrazide
levarterenolum levarterenol lévartérénol	(−) α-3,4-dihydroxyphenyl-β-aminoethanol (−) α-dihydroxy-3,4 phényl β-amino éthanol
levomethorphanum levomethorphan lévométhorphane	(−) 3-methoxy-*N*-methylmorphinan (−) méthoxy-3 *N*-méthylmorphinane
levorphanum levorphan lévorphane	(−) 3-hydroxy-*N*-methylmorphinan (−) hydroxy-3 *N*-méthylmorphinane
mannitoli hexanitras mannitol hexanitrate hexanitrate de mannitol	
menadioli natrii sulfas menadiol sodium sulfate sulfate sodique de ménadiol	2-methyl-1,4-naphthoquinol disodium sulfate sulfate disodique de méthyl-2 naphtoquinol-1,4

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
mercaptaminum mercaptamine mercaptamine	β-mercaptoethylamine β-mercaptoéthylamine
mercurobutolum mercurobutol mercurobutol	4-*tert*-butyl-2-chloromercuriphenol *tert*-butyl-4 chloromercuri-2 phénol
metaraminoli bitartras metaraminol bitartrate bitartrate de métaraminol	(−) 1-*m*-hydroxy-2-amino-1-propanol hydrogen (+) tartrate (+) tartrate monobasique de (−) *m*-hydroxy-1 amino-2 propanol-1
metharbitalum metharbital métharbital	5,5-diethyl-1-methyl barbituric acid acide diéthyl-5,5 méthyl-1 barbiturique
methenaminii tetraiodidum methenaminium tetraiodide tétraiodure de méthénaminium	hexamethylenetetraminium tetraiodide tétraiodure d'hexaméthylène tétraminium
methylbenzethonii chloridum methylbenzethonium chloride chlorure de méthylbenzéthonium	benzyldimethyl-2-[2-(*p*-1,1,3,3 -tetramethylbutyl-cresoxy)ethoxy] ethylammonium chloride chlorure de benzyldiméthyl [(*p*-tétraméthyl-1,1,3,3 butylcrésoxy)-2 éthoxy]-2 éthylammonium
methylrosanilinii chloridum methylrosanilinium chloridum chlorure de méthylrosanilinium	crystal violet violet cristallisé
nalorphinum nalorphine nalorphine	*N*-allylnormorphine *N*-allylnormorphine
natrii ascorbas sodium ascorbate ascorbate de sodium	
natrii dehydrocholas sodium dehydrocholate déhydrocholate de sodium	
natrii morrhuas sodium morrhuate morrhuate de sodium	the sodium salts of the fatty acids of cod-liver oil les sels sodiques des acides gras de l'huile de foie de morue
natrii tetradecylis sulfas sodium tetradecyl sulfate sulfate tétradécyl de sodium	sodium 7-ethyl-2-methylundecyl-4-sulfate éthyl-7 méthyl-2 undécyl sulfate-4 de sodium

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
nitrosulfathiazolum nitrosulfathiazole nitrosulfathiazol	2-(*p*-nitrophenylsulfonamido) thiazole (*p*-nitrophénylsulfamido)-2 thiazol
octamylaminum octamylamine octamylamine	amylaminomethylheptane amylamino méthyl heptane
oxydipentonii chloridum oxydipentonium chloride chlorure d'oxydipentonium	5,5′-bis (trimethylammonium) dipentyl ether dichloride dichlorure de l'éther dipentyl bis (triméthylammonium)-5,5′
oxyphenonii bromidum oxyphenonium bromide bromure d'oxyphénonium	diethyl-(2-hydroxyethyl) methylammonium bromide α-phenyl-α-cyclohexylglycolate α-phényl α-cyclohexyl glycolate du bromure du diéthyl (hydroxy-2 éthyl) méthyl ammonium
oxytetracyclinum oxytetracycline oxytétracycline	an antibiotics substance obtained from *Streptomyces rimosus* (terramycin) une substance antibiotique produite par *Streptomyces rimosus* (terramycine)
paroxypropionum paroxypropione paroxypropione	4-hydroxypropiophenone hydroxy-4 propiophénone
parethoxycainum parethoxycaine paréthoxycaïne	diethylaminoethanol 4-ethoxybenzoate éthoxy-4 benzoate de diéthylaminoéthanol
pentaerithrityli tetranitras pentaerithrityl tetranitrate tétranitrate de pentaérithrityle	
phenacemidum phenacemide phénacémide	phenylacetylurea phényl acétyl urée
phenarsoni sulfoxylas phenarsone sulfoxylate sulfoxylate de phénarsone	sodium 3-amino-4-hydroxyphenylarsonate-*N*-methanal sulfoxylate amino-3 hydroxy-4 phénylarsonate *N*-méthanal sulfoxylate de sodium
phenpromethaminum phenpromethamine phénprométhamine	*N*, *β*- dimethylphenethylamine *N*, *β*- diméthyl phénéthylamine
phentolaminum phentolamine phentolamine	2-(*m*-hydroxy-*N*-*p*-tolylanilinomethyl)-2-imidazoline (*m*-hydroxy *N*-*p*-tolylanilino méthyl)-2 imidazoline-2
phenylbutazonum phenylbutazone phénylbutazone	3,5-dioxo-1,2-diphenyl-4-*n*-butylpyrazolidine dioxo-3,5 diphényl-1,2 *n*-butyl-4 pyrazolidine

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
phytomenadionum phytomenadione phytoménadione	2-methyl-3-phytyl-1,4-naphthoquinone (vitamin K_1) méthyl-2 phytyl-3 naphtoquinone-1,4 (vitamine K_1)
piperoxani hydrochloridum piperoxan hydrochloride chlorhydrate de pipéroxane	2- (1-piperidylmethyl) 1,4-benzodioxan hydrochloride chlorhydrate de (pipéridylméthyl-1)-2 benzodioxane-1,4
piridocainum piridocaine piridocaïne	*β*- (2-piperidyl) ethyl *o*-aminobenzoate *o*-aminobenzoate de *β*-(pipéridyl-2) éthyle
primaquinum primaquine primaquine	8-(4-amino-1-methylbutylamino)-6-methoxyquinoline (amino-4 méthyl-1 butylamino)-8 méthoxy-6 quinoléine
probarbitalum natricum probarbital sodium probarbital sodique	sodium derivative of 5-ethyl-5-*iso*propyl-barbituric acid dérivé sodique de l'acide éthyl-5 *iso*propyl-5 barbiturique
procainamidum procainamide procaïnamide	4-amino-(2-diethylaminoethyl) benzamide amino-4 (diéthyl-2 aminoéthyl) benzamide
propyliodonum [4] propyliodone propyliodone	propyl-3,5-diiodo-4-pyridone acetate acétate de propyl diiodo-3,5 pyridone-4
pyroxylinum pyroxylin pyroxyline	soluble guncotton fulmicoton
racemethorphanum racemethorphan racéméthorphane	(±) 3-methoxy-*N*-methylmorphinan (±) méthoxy-3 *N*-méthylmorphinane
racemorphanum racemorphan racémorphane	(±) 3-hydroxy-*N*-methylmorphinan (±) hydroxy-3 *N*-méthylmorphinane
salicylamidum salicylamide salicylamide	2-hydroxybenzamide hydroxy-2 benzamide
subathizonum subathizone subathizone	4-ethylsulfonylbenzaldehyde thiosemicarbazone thiosemicarbazone d'éthylsulfonyl-4 benzaldéhyde

[4] Replaces " propiodonum ", which appeared in a previous list (WHO/Pharm/222).

International non-proprietary name (Latin, English, French)	*Chemical name or description* (English, French)
sulfamethizolum sulfamethizole sulfaméthizol	5-sulfanilamido-2-methyl-1,3,4-thiodiazole sulfanilamido-5 méthyl-2 thiodiazol-1,3,4
sulfisomidinum sulfisomidine sulfisomidine	2,4-dimethyl-6-sulfanilamidopyrimidine diméthyl-2,4 sulfanilamido-6 pyrimidine
suxamethonii chloridum suxamethonium chloride chlorure de suxaméthonium	bis-(2-dimethylaminoethyl) succinate bismethochloride diméthochlorure de succinate de bis-(diméthylamino-2 éthyle)
suxethonii chloridum suxethonium chloride chlorure de suxéthonium	bis-(2-dimethylaminoethyl) succinate bisethochloride diéthochlorure de succinate de bis-(diméthylamino-2 éthyle)
thiacetarsamidum natricum thiacetarsamide sodium thiacétarsamide sodique	disodium salt of *p*-[bis-(carboxymethyl-mercapto) arsino] benzamide sel disodique de *p*-[bis-(carboxy méthyl mercapto) arsino] benzamide
thiodiglycolum thiodiglycol thiodiglycol	2,2′-dihydroxyethyl sulfide sulfure de dihydroxyéthyle-2,2′
tocamphylum tocamphyl tocamphyl	diethanolamine salt of tolylmethyl carbinol mono-D-camphoric acid ester sel de diéthanolamine de l'ester mono-D-camphorique de tolylméthyl carbinol
tuaminoheptanum tuaminoheptane tuaminoheptane	1-methylhexylamine méthyl-1 hexylamine
urethanum [5] urethane uréthane	ethyl carbamate carbamate d'éthyle

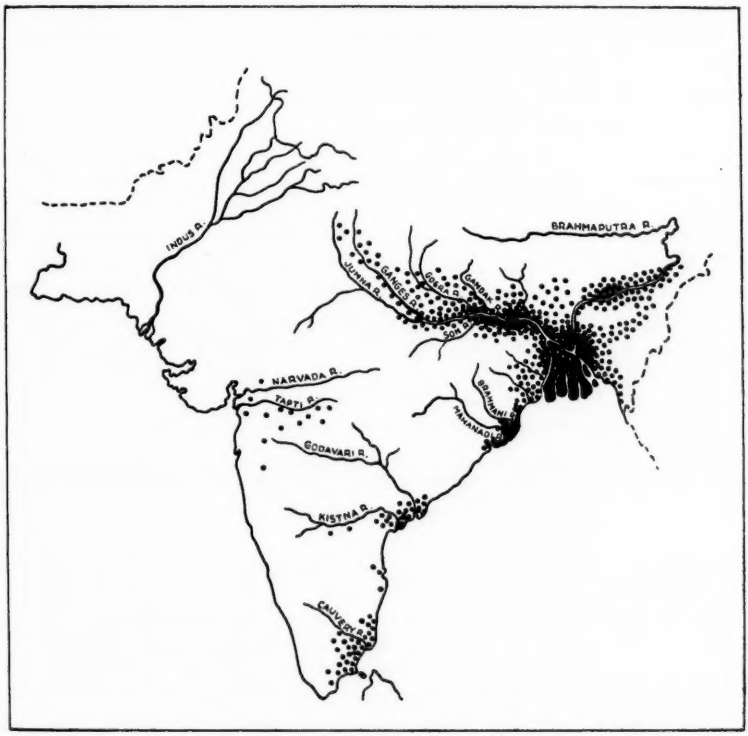
[5] Replaces "ethylurethanum", which appeared in a previous list (*World Hlth Org. techn. Rep. Ser.* 1951, 35, 29).

Review of WHO Publications

CHOLERA INCIDENCE AND ENDEMICITY

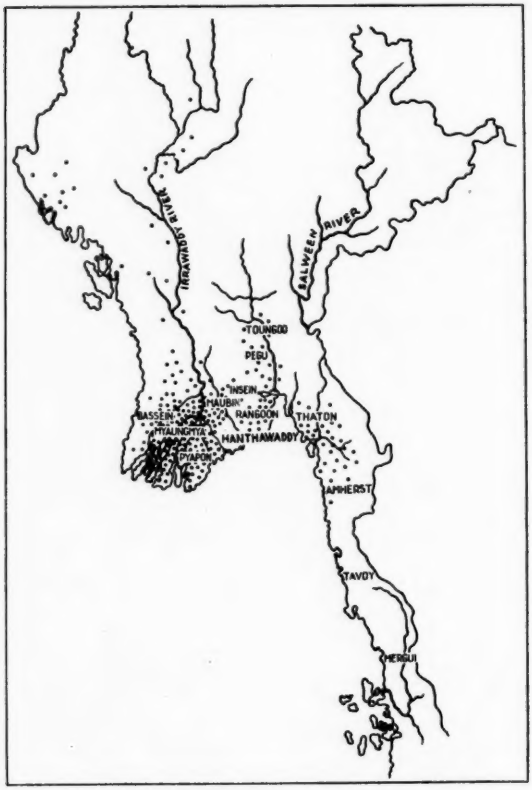
No clear-cut definition of the term "endemicity" as it applies to cholera is yet available; but, for practical purposes, areas in which the disease continues to persist, and in which it may or may not at times assume epidemic proportions, may be considered "endemic". Contrary to what might be expected, however, it is not usually possible in such endemic areas to trace the spread of the infection from person to person;

FIG. 1. CHOLERA ENDEMICITY LEVEL IN INDIA AND PAKISTAN, 1901-45*



*The endemicity level is shown in relation to the river system by variations in the density of the dots. This level is expressed by the average annual cholera death-rate during the fifteen years of lowest prevalence in the period 1901-45.

FIG. 2. CHOLERA ENDEMICITY LEVEL IN BURMA, 1918-38*



*The endemicity level is shown in relation to the river system by variations in the density of the dots. This level is expressed by the average annual cholera death-rate during the seven years of lowest prevalence in the period 1918-38.

all that can be established, particularly during the inter-epidemic periods, is a persistent occurrence of cholera cases and deaths. Since a study of case relationship is not feasible, the question of persistence of cholera may be approached by analysing figures for incidence and mortality for many years. If the periods of freedom from infection are frequent and of long duration, then the area under consideration may be classed as "non-endemic"; on the other hand, the presence of cholera cases and deaths throughout the period under review would indicate a persistence of the infection and a certain degree of endemicity.

The results of a study of this type have been published in a recent number of the *Epidemiological and Vital Statistics Report*.[1] Dr. S. Swaroop, Chief of the WHO Statistical Studies Section, has, with the assistance of Dr. R. Pollitzer, analysed figures showing cholera incidence in several countries for a varying number of years in order to follow the trend of the infection and to study the distribution of endemic foci. The statistics reveal that countries in Africa, Europe, and America which formerly suffered cholera outbreaks are now usually free from this disease and that, apart from an epidemic in Egypt in 1947, cholera has not appeared outside Asia since 1930. Even within Asia some countries in the east, such as Japan and the Philippines, have remained free, or almost free, from cholera in recent times until refugee movements following the second World War led to reappearance of the disease in certain localities.

Despite a progressive reduction in cholera-infected areas during the past half-century, apparently endemic foci continue to exist in some delta regions, particularly those around the Bay of Bengal. Fig. 1 and 2 show the location of these foci of infection, but it should be noted that they indicate only the regions within which endemic foci are supposed to exist. The exact location of such foci would have to be determined by a detailed analysis of cholera statistics for smaller population units than those for which data are at present available.

On the basis of this study, it may be concluded that all supposedly cholera-endemic foci are (1) adjacent to rivers, thus indicating a close relationship of cholera endemicity to surface water systems; (2) situated in low-lying areas, not more than 100 feet (30 metres) above sea-level; and (3) located in densely populated regions.

[1] *Epidem. vital Statist. Rep.* 1952, 5, 569

CAUSES OF DEATH IN EUROPE AND IN SOME NON-EUROPEAN COUNTRIES

The most recent statistical information available for a considerable number of countries on causes of death, classified by age and by sex, has been published in the *Epidemiological and Vital Statistics Report*.[1] This *Report* is interesting for several reasons :

First, it gives data collected from five continents. Whereas the mortality figures previously published were either for Europe [2] or for non-European

[1] *Epidem. vital Statist. Rep.* 1952, 5, 371

[2] *Chron. World Hlth Org.* 1949, 3, 122; 1950, 4, 349; 1951, 5, 239

countries, the present compilation includes statistical data from every part of the world.

Secondly, the statistics refer, depending on the country, to the years between 1947 and 1951, the most complete information being that for 1950. This indicates how rapidly these data are analysed by national statistical offices and transmitted by Member States to WHO to be made available to interested administrations and investigators.

Thirdly, publication of this up-to-date information makes possible, now and in the years to come, an evaluation of the results of campaigns undertaken against communicable diseases in various parts of the world, of the extent to which mortality from each of the principal diseases has dropped, and of the benefits to a country of preventive and social hygiene measures and of early case-finding of communicable diseases—the effects of which are reflected particularly in a lowering of the mortality-rate among infants and children. The analysis of the information by sex also adds to the value of these data. In fact, as the authors of this publication state, statistics presented in this way may be considered as a " barometer of public-health conditions ".

Fourth, the advantages which public-health administrations may draw from the study of these statistics may encourage the various States to supply more complete and more recent data. Already, as the authors point out, " the ever-increasing number of recent series which it has been possible to publish demonstrates the interest of the various countries in this type of information ".

The publication of these statistics for the most recent years for which they are available—grouped in 59 tables—is of particular interest because some of the mortality statistics presented are already based on the sixth (1948) revision of the International Lists of Diseases and Causes of Death, as given in the *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*.[3] They are grouped according to the " Abbreviated List of 50 Causes for Tabulation of Mortality " contained in the Manual.[4] The 1949 figures for two countries were based on this List, and 16 other countries used it for the first time in publishing their mortality statistics for 1950.

In presenting the statistics based on the 1948 International Statistical Classification of Diseases, Injuries, and Causes of Death, the authors recommend caution in interpreting time trends in mortality by disease. Apart from the changes in the content of the categories, there are also other factors to be considered which affect the comparability of the mortality figures based on the fifth and sixth revisions of the International Lists.

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[3] World Health Organization (1948) *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*, Geneva, 1

[4] See p. 361 of the Manual.

The Manual contains certain rules for the selection of the underlying cause of death so that mortality statistics may be based on uniform criteria, replacing those in common use in different countries and varying accordingly. The International Form of Medical Certificate of Cause of Death, which was adopted with the lists given in the Manual, aims, with eventual statistical classification in mind, to aid physicians in correctly indicating the underlying cause of death and the morbid conditions which contributed to the fatal outcome.

The changes in classification and the application of new rules for the selection of the underlying cause of death have caused a break in the comparability of statistics relative to certain causes of death from one year to another. Those headings the contents of which have been either expanded or curtailed are the most affected. Thus, the heading " Scarlet fever " in the 1938 abridged list has become in the 1948 Abbreviated List " Scarlet fever and streptococcal sore throat "; " Nephritis " has become " Nephritis and nephrosis "; and " Syphilis " has become " Syphilis and its sequelae ". Diseases of infants less than four weeks old, even when specifically diagnosed, come under a new heading, " Infections of the newborn ", which reduces the number of entries under " Pneumonia " and " Gastritis, duodenitis, enteritis, and colitis except diarrhoea of the newborn ".

The influence of the new rules for the classification of causes of death is particularly evident in the case of diabetes. When, for example, it was decided in Canada and the USA that the choice of cause of death would rest with the physician issuing the certificate and would no longer be made according to rules in practice up to that time, the figures for deaths from diabetes dropped by 45% for 1949 in Canada and by 43% for 1949-50 in the USA.[5]

The apparent variations due to the changes described above, and reflected in the comparative figures for deaths from certain causes, are clearly shown in the tables published in the present study, particularly in those which illustrate the result of a double classification of certain causes of death according to the abridged lists of 1938 and of 1948. Although these changes involve a break in the statistical continuity of certain data, the gradual adoption of the new International Statistical Classification of Diseases, Injuries, and Causes of Death by an increasing number of countries will, in the future, make death-rates for various causes in different countries more comparable. The information published in this report, which must be interpreted with a certain amount of reserve in view of the foregoing, will serve as a basis for comparison of statistics in years to come, when the figures from an ever-increasing number of countries will be based on uniform criteria.

[5] World Health Organization (1952) *Comparability of statistics of causes of death according to the fifth and sixth revisions of the International List*, Geneva

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows are of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports are therefore published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

Industrial Psychiatry in the USA

Dr. Erland Mindus, consulting physician to the Institute of Applied Psychology, University of Stockholm, visited Canada, Great Britain, and the USA on a WHO fellowship to study industrial psychiatry in these three countries. There follows a brief summary of some of his observations on the USA.

Psychiatrists were employed in industry in the USA as early as 1916. During the second World War, an increasing number of psychiatrists were used by industry to aid in solving the adjustment problems of disabled employees; such services were abandoned after the war.

At the moment, the number of industrial psychiatric projects is small; but interest in such projects, or at least in efforts to improve " human relations ", is gaining ground. Both management and labour are to some extent aware of the fact that at least one-third of all sickness absenteeism in industry is caused by emotional disturbances.

There is still much need of clarification of what the contributions of psychiatrists to industry can be. Generally, the major psychoses are not a great problem in industry; and the minor psychiatric difficulties are usually handled by psychologists, social workers, nurses, industrial medical officers, or even lay persons who seem to have a knack for this type of work. Many industrial grievance discussions which are rooted in emotional problems are not recognized as such and are " solved " by firing the employees concerned.

Projects in industrial psychiatry range from slight psychiatric " first aid " by plant medical departments to actual psychiatric counselling in the form of assistance in policy determination at a top level—which is essentially preventive psychiatry. In the latter case, an attempt is made to find out which managers might be called " stress-producers " and what points in the organization are apt to cause emotional tensions.

The psychotherapy given in industry is mostly short-term, aiming to give emotional release and a better understanding of the problems involved. Leave of absence for emotional reasons is not frequent. It is generally thought that neurotics do much better when they continue working. In instances in which neurotics with compulsory drives or much aggressiveness are a particular problem because they act in a supervisory capacity and are a source of disturbance to the employees under their command, therapy of the employee or employees concerned is sometimes followed by similar treatment of the supervisor. Changing the placement of the employee is usually avoided since the long-term results of such a procedure are not satisfactory.

A valuable by-product of psychiatric services in industry is that other company doctors and nurses may, through the efforts of the psychiatrist, learn to handle a great number of emotional problems.

An interesting development in the USA is the utilization of the services of commercial psychological firms, in which consulting psychologists give advice to top management only, sometimes beginning with a psychological evaluation of the chief executive to determine what kind of personality he has and how this is reflected in the management of the firm.

A new field which has been opened in recent years is the treatment of alcoholics. The Yale University centre for alcoholic studies gives a figure of two million hidden cases of alcoholism in industry. During the past four years, an increasing number of industries have, with the co-operation of medical officers, psychiatrists, and various community agencies, started treatment programmes to combat alcoholism.

The position of the psychiatrist in the industrial organization is not uniform. He is most commonly on the staff of the medical department and reports to the medical director and, through him, to the personnel division; in some cases, however, the psychiatrist is a member of the personnel division or directly under one of the vice-presidents.

Dr. Mindus feels that at present the industrial psychiatrists do not engage very much in formal training of personnel and that they do not exert a very great direct influence on management policies. Contacts between the psychiatrists and the labour unions seem to be very few. It is perhaps just chance, but most of the work of the industrial psychiatrists is devoted to white-collar workers.

A training programme for industrial psychiatrists was started a few years ago at Cornell University. The aim of the training is to enable the psychiatrist to eliminate conditions in the work environment that aggravate internal conflict within individuals and block co-operative effort.

While special research in occupational psychiatry is extremely scarce, there are many psychiatric studies being conducted which will later be of importance for this particular subject. Dr. Mindus was impressed by the trend to combine in such research the work of anthropologists, sociologists, psychologists, psychiatrists, and even epidemiologists.

Notes and News

Conferences in Eastern Mediterranean Region

Tuberculosis

In late November 1952, WHO tuberculosis staff from five of the six WHO Regions —the Americas, the Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific—met at Alexandria to discuss WHO-assisted antituberculosis campaigns. This group, which was under the chairmanship of Dr. J. Holm, Chief of the Tuberculosis Section, Headquarters, emphasized the need to integrate tuberculosis-control programmes with other public-health work and recommended that surveys to determine the prevalence of tuberculosis should be combined, when feasible, with surveys of other communicable diseases. The role of public-health education in the control of infectious diseases was stressed, and methods of establishing and administering tuberculosis demonstration centres and of conducting BCG-vaccination campaigns were discussed.

Mentcl health

A meeting to plan a seminar on mental health to be held in the Eastern Mediterranean Region in 1953 took place at Alexandria in early December 1952. Specialists from Egypt, Iraq, Lebanon, Sudan, and Syria met under the chairmanship of a WHO consultant on mental health, Professor G. Kraus, psychiatrist at the University Clinic, Groningen, the Netherlands. The members of the group revealed that mental health services are very little developed or not yet started in the countries of the Eastern Mediterranean Region. They emphasized the need for increased numbers of trained personnel for mental health work and suggested that methods for training such personnel be one of the topics of discussion at the projected seminar. Other topics suggested were the creation and organization of psychiatric treatment, on both an in-patient and an out-patient basis, and the problem of drug addiction, particularly addiction to hashish.

Tuberculosis Control in India

A report on the WHO/UNICEF BCG-vaccination campaign in India, which continues work begun by the International Tuberculosis Campaign, gives the following cumulative totals as of the end of October 1952 :

Period	*Tuberculin-tested*	*Vaccinated*
Up to 30-6-51 (International Tuberculosis Campaign)	4,129,570	1,372,029
1-7-51 to 31-10-52	7,435,814	2,314,163
Total	11,565,384	3,686,192

Health Conditions among Palestine Refugees

For the past four years WHO has planned and carried out the health programme of the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWAPRNE), which cares for more than 850,000 people. A recent report to the Organization states that the health conditions of the refugees during 1952 were good. No cases of plague, cholera, smallpox, yellow fever, or typhus were reported; there were a few cases of endemic typhus fever and several of tick-borne relapsing fever. Trachoma continues to be prevalent, but control measures have been undertaken. Tuberculosis is as much a problem among the refugees as it is among the people of the host countries, and there is need for further control efforts. The fight against malaria has met with considerable success : the Jordan Valley, which was previously almost uninhabitable because of this disease, now harbours 90,000 refugees; a downward trend in the incidence of malaria has also been reported in other areas in which refugees live.

A WHO/FAO nutrition survey revealed that there is relatively little malnutrition among the refugee children. Further assessments now being conducted among patients attending clinics have shown that less than 4% of the 60,000 persons examined each month display signs of nutritional deficiency.

Improvement of sanitary facilities is attested to by an absence of epidemics of filth-borne diseases.

There are 79 UNRWAPRNE-operated clinics and almost 2,000 hospital beds available for the refugees. The Agency has an annual health budget of $2,000,000 and employs about 2,000 health workers. Voluntary agencies and the host governments also collaborate in the health care of the refugees.

FIG. 3. PALESTINE REFUGEES — I

Mothers learn to bathe their babies at one of the maternal and child health centres provided for the refugees

FIG. 4. PALESTINE REFUGEES — II

This refugee child has come, with an improvised pail, to seek his ration of the food provided by UNICEF

Biological Standardization

Replacements of two international biological standards have been established : the Third International Standard for Insulin, and the Second International Standard for Penicillin.[1] International biological standards have now been established for *Brucella abortus* Antiserum (for diagnostic purposes), for Scarlet Fever Streptococcus Antitoxin, and for Dimercaprol.

The WHO Expert Committee on Biological Standardization has decided that it will not undertake replacement of the current international standard for Vitamin A (pure vitamin A acetate), the stock of which will probably be depleted by about the end of 1953. This material, which is being widely distributed from the Department of Biological Standards of the National Institute for Medical Research, London, is apparently being used at the present time almost entirely for the calibration of spectrophotometric instruments rather than as a standard in biological assays. The committee feels that it is no longer the appropriate body to carry the responsibility for the distribution of this standard, or of any other of the international biological standards which can be clearly characterized by their chemical and physical properties. A proposal is therefore under consideration that the responsibility for collecting, maintaining, and distributing all such " authentic chemical substances " should be transferred to the Expert Committee on the International Pharmacopoeia.

[1] Articles on these two standards will appear in forthcoming numbers of the *Bulletin of the World Health Organization*.

CORRIGENDUM

1952, Vol. 6, No. 10 (October), p. 301, 4th line from bottom

Delete " The most rapid test ... serum."

Insert It was known that, by means of the slide modification of the Meinicke reaction, it was possible to give the results of a single blood-sample within 45 to 60 minutes after it had been collected. The Meinicke test is performed on active serum and, with the slide modification, only a small drop of serum is required. When that drop of serum is available, the result of the test can be read after about 25 minutes.

WORLD HEALTH ORGANIZATION: MONOGRAPH SERIES

The *World Health Organization: Monograph Series* contains reprints and, in some cases, complete translations of important studies originally published in the *Bulletin of the World Health Organization*, or articles of particular interest previously unpublished.

The following have recently been issued :

No. 7

THE COST OF SICKNESS AND THE PRICE OF HEALTH

C.-E. A. WINSLOW

A study illustrating the contention that the cost of sickness, in reduced economic productivity and in curative medicine, to the community is greater than the cost of a sound public-health programme.

English edition, 1951; 106 pages, bibliographies, index

Price : 7/6 $1.50 Sw. fr. 6.—

No. 8

KWASHIORKOR IN AFRICA

J. F. BROCK & M. AUTRET

A report on an investigation into the various features of kwashiorkor in Africa, conducted as the result of a recommendation of the Joint FAO/WHO Expert Committee on Nutrition, in which the clinical characteristics and incidence of the syndrome, the role of diet and local food customs of the people, and of other factors (such as tropical parasitism), in its occurrence, and measures for prevention and treatment, are discussed.

English edition, 1952; 78 pages, 11 figures, 5 tables, bibliography

Price : 5/- $1.00 Sw. fr. 4.—

No. 9

BIOLOGY OF ANOPHELES GAMBIAE

Research in French West Africa

M. H. HOLSTEIN

A study summarizing present-day knowledge on *Anopheles gambiae*, the chief vector of malaria in Africa. The author, who prefaces each chapter with a critical review of previous work, describes his own recent researches, which throw light on many hitherto unsolved problems of the biology of this species in French West Africa.

English edition in preparation

Price : 10/- $2.00 Sw. fr. 8.—

MATERNAL CARE AND MENTAL HEALTH

by

JOHN BOWLBY

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The quality of parental care which a child receives in his earliest years is now recognized as of vital importance for his future mental health. Direct, retrospective, and follow-up studies have revealed the extensive and harmful consequences, often irremediable, upon the child's development of depriving him of maternal care. Since this situation is injurious to the mental and social welfare of the whole community, attempts to prevent it must be made. But how can maternal deprivation be prevented ? There is no truer maxim than " there's no place like home ", and even bad homes are often better than good institutions. The task, first and foremost, is to improve care not outside the home, but inside it. The problem of child welfare is not isolated, but inextricably mixed with that of family care and mental health in general, for neglected children frequently become neglectful parents.

In this aspect of mental health, the twentieth century offers an opportunity for equalling the nineteenth-century achievements in public and physical health. Once it is universally recognized that mental development is as important to the child as physical development, the paramount importance to the community of the role of the mental health worker will be realized.

These are the conclusions of a report on the mental health aspects of the problem of homeless children prepared by Dr. Bowlby on behalf of the World Health Organization as a contribution to the United Nations programme for the welfare of homeless children. In his capacity as consultant to WHO, the author visited France, the Netherlands, Sweden, Switzerland, the United Kingdom, and the United States of America, holding discussions with child-care and child-guidance workers, seeing their work, and studying the literature.

All concerned with the welfare of homeless children — whether psychiatrists, social workers, or individuals with their own problems to solve — will find this comprehensive study, based both on the literature and on personal experience and contacts, of vital interest.

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